

The health care needs of UK pensioners living in Spain: an agenda for research

Helena Legido-Quigley and Daniel La Parra

Summary: There is a growing interest in learning how older migrants adapt to their new country of residence, in understanding their motivations for migration and the factors that influence international retirement migration patterns. However, there has been little research into the health and health care needs of international migrants retiring to other countries. This paper presents findings on health status and utilisation of health services with a particular focus on UK pensioners retiring to Spain. Future research should focus on the health needs of pensioners and their perspectives as to whether and how these health needs are met.

Keywords: Older migrants, Inequalities in access, Social security, Spain, UK

A key contextual factor which helps to explain international retirement migration patterns is the changing regulatory framework of the European Union (EU). This phenomenon is embedded in EU legislation and social policy considerations, including Articles 48 and 49 of the Treaty of Rome on the freedom of movement, the Single European Act which removes barriers to property rights across Member States, Article 8 of the Treaty of the EU which confers limited electoral rights and the Social Charter which envisages the potential to harmonise pension and welfare systems across the EU.¹ In addition, in the mid 1970s the then European Economic Community recognised that freedom of movement should not be restricted to the healthy. In 1971, Council Regulation (EC) No. 1408/71 on the application of social security schemes provided avenues for statutory

cover of treatment received outside the state of residence or affiliation. This included EU pensioners deciding to retire to another Member State through the E121 scheme (See Box 1).

Some EU citizens have seen these mechanisms as an opportunity to move to another Member State and they are likely to have been a factor in the growing numbers of northern Europeans retiring to southern Europe. Although this is a phenomenon that has existed for many years (for example, Irish people returning to Ireland after spending their working lives in England) the numbers involved, and the destinations being chosen, have changed greatly. There are now many people from northern Europe retiring to southern Europe, in particular to Spain, France, Portugal, Italy, Greece and Bulgaria, as well as to candidate countries such as Croatia.²

The phenomenon of international retirement migration in Europe

Systematic academic interest in the study of European international retirement migration only emerged in the mid-1990s, mostly in the field of migration studies and social gerontology. The main focus of social gerontology is on the

Box 1: Background to the E121 scheme

The process described here refers to the administrative steps a pensioner has to go through when he or she decides to move to another Member State.

The individual applies for an E121 form in their home country so that their social rights are transferred from the social security system of the home country to the 'receiving country'. Together with this transfer of rights, a lump sum of money, agreed upon in the Social Commission on Migrant Workers, is also transferred to the central government of the receiving country to cover costs for health care. The information is passed to the region or locality where the pensioner is planning to settle. The long-term resident receives a national health insurance card in the new country and is thus integrated into the system. No distinctions are made between older newcomers and any other member of the social security system.

These communication routes and information flows involve no direct contact between the local health care provider in the new country and the state-level public authorities of the home country. Thus, in the event of the death of a long-term resident, the home country might not be informed and will therefore continue to transfer money.

Through the E121 scheme long-term residents obtain the right to health care in the new or 'receiving country' and at the same time renounce their right to health care at home. However, Directive 1408/71 also requires that the receiving country provide the pensioner with an E112 (form for planned treatment abroad), regardless of whether the treatment is already available in the 'receiving country'.

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reconstruction of older people's lives by connecting individual biographies to the history of society and the study of social change. Through the analysis of different cohorts of older migrants and the identification of positive attributes of retirement in later life, it has helped to challenge previous misconceptions on retiring migrants by providing a more solid empirical base.¹

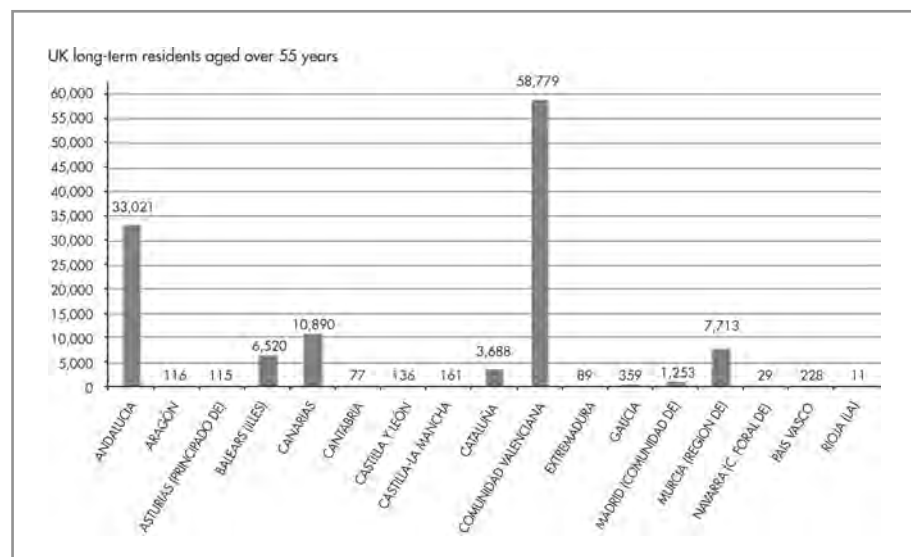
A growing literature has focused on determining the number of retirees migrating in Europe, choice of location and reasons for migrating. Key socio-economic and personal characteristics of migrants, including life-stage, cultural, attitudinal, recreational and environmental factors and personal influences have been analysed. Locations of study have included coastal Croatia, Spain (Majorca, Costa Blanca, Costa del Sol), Italy (Tuscany) and Malta.

*“in 2006, more than 300,000
UK citizens retired to other
Member States”*

This research has illustrated how there has been an increase in the number of older Europeans migrating in retirement. This needs to be understood in the context of a rise in older people's income and assets, as well as major transformations in their preferences and opportunities.¹ Moreover, increasing life expectancy, along with the increasing availability of new medicines and medical technologies, has meant that a growing number of older people are living healthier and longer lives. At the same time older people in most northern European countries are no longer expected to take care of their grandchildren or children and are to a greater extent more concerned with enjoying their lives.

The rise in consumption and mass communication combined with the move in society towards individualism has also influenced older individuals' motivation to move abroad. As Lipovetsky notes, we live in a society with unprecedented social temporality marked by the primacy of the here-and-now.³ This individualism and social temporality also applies to older people. Thus, pensioners retiring abroad can increasingly access the internet, affordable telephone calls and own language cable television. With the advent

Figure 1: UK long-term residents aged over 55 years in Spain by Autonomous Community



Source: Instituto Nacional de Estadística 2006.¹⁰

of low-cost airlines there are also greater opportunities for travelling between home and host country for both migrants and their relatives.

Some of the evidence on patterns of European retirement migration identifies a series of key factors encouraging older people to retire abroad. Božić looking at ex-patriots in Croatia identified the most important factors for migration as climate, geopolitical location, level of property prices and familiarity with the region.⁴ One study of 266 retirees to Tuscany⁵ and another looking specifically at UK pensioners retiring to Spain reported similar factors including favourable natural resources and landscape, respect for children and older people, friendly atmosphere, security and the slow pace of life.⁶

In addition, older people preferred Spain over the UK because of perceived advantages to health, a good climate, the opportunity to be active, the possibility of spending more time outdoors and the wider availability of recreational clubs and associations. This study also emphasised the lower costs of living in Spain as an advantage over the UK in terms of value-for-money.⁶

Another study reported that UK pensioners form well-defined territorial and social units, benefiting from the strong value of their currency and previous presence in Spain as tourists or residents. However, a lack of proficiency in Spanish has prevented them from developing closer links with the local community.⁷ Other studies also suggested that these EU

pensioners tend to be isolated with few, if any, close relationships with the local population.^{4,7,8}

The scale of the phenomenon

There has been a significant growth in the number of UK citizens retiring abroad. Aggregate data from the Department of Work and Pensions indicated that, in 2006, more than 300,000 UK citizens retired to other Member States. This data is based on the number of pensions transferred. A breakdown of countries of destination indicates that UK citizens have a primary affinity with Ireland (103,667) followed by Spain (76,357) and then to France, Italy and Germany each of which receives more than 30,000 migrants.⁹

The information available on the UK population in Spain is somewhat limited. The Instituto Nacional de Estadística (INE) estimates that there are currently 314,098 UK citizens living in the country.¹⁰ That would make UK citizens the fourth largest foreign community in Spain, following Moroccans, Romanians and Ecuadorians. It is estimated that 53% are over the age of fifty. However, the true figures are likely to be higher because of the underreporting of pensioners who stay more than three months per year in two (or three) countries. These pensioners may travel back and forth without regularising their situation each time they move.

The INE estimates, through the figures provided by the municipalities (the padrón), that the total number of UK men aged over sixty-five and UK women over sixty was 87,359 in January 2007. This is

possibly the most reliable source of data on foreign pensioners since migrants who wish to access health and social services need to register with local municipalities. However, this register is not used to define the administrative residential situation of UK pensioners, since municipalities are not responsible for processing residence permits. In fact, only 56% of the UK population registered with the *padróns* hold a residence permit. Figure 1 shows UK citizens resident in Spain by Autonomous Community (AC) and age in January 2006. The ACs with the most UK residents over fifty-five were Valencia with 58,779, Andalucía (33,021), Canarias (10,809) and Baleares (6,520).

Health, health care arrangements and experiences of EU pensioners retiring to Spain

Looking at some studies on the health care arrangements of pensioners retiring to another Member State, one study, based on interviews with key informants and a survey amongst Germans aged fifty-five plus living in Majorca in 1999, identified several problems impacting on their health.¹¹ These included housing and dwelling locations that were perceived not to be compatible with the requirements of older people; the lack of harmonisation of the health and social care systems between Germany and Spain which complicated applying for access to the health care system, and the scarcity of welfare institutions for those who had become frail. Another study using in-depth interviews and focus groups obtained similar results after studying the retired population in Cambrils and Calvia (Spain).¹²

The migration of older Swiss people to the Costa Blanca (Spain) in the period from 1999 to 2001 has also been analysed.¹³ Using a mix of methods, it suggested that the majority of pensioners did not wish to return to Switzerland under any circumstances, not even in the event of the death of their partner. While this information is not directly related to the health and health care needs of Swiss retirees in Spain, it points to a potential great future demand for health care services for this population.

In contrast, Norwegian migrants were found to have very different views.¹⁴ Based on interviews with eighteen people aged 60–75 years, the main concerns voiced were the loss of social rights previously enjoyed in Norway and problems related to the process of repatriation. There was a perceived lack of nursing homes in Spain

having staff familiar with the Norwegian language. These Norwegian pensioners tended to prefer to move back to Norway to spend their 'last days' and be buried near their families.

UK migrant retirees

As indicated above, there is little research relating specifically to the health care needs of migrants retiring abroad. We now discuss the situation in respect of UK migrants, drawing on data both from the 'Europe for Patients' project¹⁵ which explored the health care arrangements of long-term residents, including pensioners in Spain through stakeholder analysis, and from research carried out by La Parra and Mateo.¹⁶ The latter looked at the general health of UK older citizens living on the Costa Blanca and their access to and utilisation of health care services (see Box 2).

"the lack of long-term care and home care in Mediterranean countries is a concern"

All the foreigners registered in the *padrón* in Spain, have the right to access the National Health System. The Spanish Law on Foreign Nationals (LE 4/2000) guarantees this right to all EU and non-EU migrants regardless of whether they are undocumented or legal migrants. Once a migrant has registered in a municipality, he/she can apply for a health card. The total number of health cards issued in Spain for UK Citizens is difficult to estimate, as each AC manages their health care service independently.

As of March 2007, in the Valencian AC alone the total number of UK citizens holding a health card was 64,820, representing 52% of the total UK population registered in the *padrón*.^{17,18} These figures suggest that some citizens have no public arrangements to cover their needs and must be using private health care in Spain or/and the National Health Service in the UK. This has been confirmed in another study which stated that 67% of UK pensioners were covered exclusively by the Spanish National Health System or the UK National Health Service, 17% by both public health care providers and private medical insurance, 12% relied exclusively on private health-care, and 3% claimed not to be covered by public or private care.¹⁶

Box 2 Health status of UK pensioners retiring abroad

- UK nationals resident on the Costa score higher than Spaniards and UK-based citizens on some indicators, with fewer mobility problems and a more positive perception of their state of health.
- It is suggested that some residents who become dependent choose to return to their home countries to seek professional help and support services.
- Other indicators suggest that all age groups are more vulnerable to mental health problems than the UK home population.
- Cigarette smoking and alcohol consumption are higher among the UK ex-pats living on the Costa Blanca; consumption of both rises when they move to Spain.
- The number of visits to a general practitioner by UK ex-pats was approximately the same as for their Spanish neighbours. Although, admissions to hospital are higher than for the Spanish, rates for UK ex-pats are comparable to those seen in the UK. This normal level of health service use results from access to multiple providers: the Valencia Region Health Service, the UK National Health Service, and the private sector
- UK residents on the Costa Blanca make relatively high use of private health care compared to the Spanish and UK populations. The reasons that encourage them to turn to the private sector are likely to be language difficulties in the public sector as well as the usual advantages, such as short waiting times, faster follow-up, fewer clinic visits and less paperwork.¹⁹
- The most commonly cited problems involved in using the Valencia Region Health Service were perceived to be communication (use of the Spanish language) and the administrative processes (information, places, rights, procedures, waiting times). However, their overall perception was quite positive.

Source: 16

Among those who benefited from public health care services, 73% made use of the Valencian Region Health Service and the remainder the UK National Health Service.

Foreign residents in Spain who do not have a Spanish Health Card are primarily those who spend half of the year in their 'home country'. In these cases, patients are only registered in one of the two health care systems. Formally they should apply for a new E121 every time they go back and forth, but this option creates a huge bureaucratic burden as it must be repeated at least twice a year.

Some long-term residents are also concerned that by applying for the E121 they will lose some social welfare benefits, due to the difference in benefits provided by each Member State. For example, pensioners in the UK have supplementary social benefits such as a winter heating allowance, disability allowances and care allowances. Another concern is the lack of long-term care and home care in Mediterranean countries where these services have traditionally been provided by the family.

Furthermore, the processes involved in transferring registration are perceived as bureaucratic and inflexible. Long-term residents who have been through the process of transferring their rights using the E121 are reluctant to engage in what is seen as a lengthy and painful process to reverse their registration. They are often afraid of losing the option of returning to their home country. Thus there are large numbers of long-term residents who opt not to regularise their situation, so forming part of the 'floating population'.¹⁵ There is no clear provision for these groups, which becomes particularly problematic for patients with chronic diseases.

"hospitals are beginning to include language skills as a criterion when hiring staff"

It is suggested that this 'floating population' of long-term residents in fact have their health care needs met primarily by means of the European Health Insurance Card (EHIC)* while in the 'receiving country'. However, this scheme is designed for use in emergency situations only and does not ensure continuity of care. Furthermore, the recording of treatment provided under the EHIC scheme is often poor, creating gaps in an individual's medical records.

It is also suggested that some pensioners do not hold the Spanish Health Card because of a lack of information or difficulties with administrative procedures.

Stakeholders report that patients are often not well informed on how the system in the country works, partly due to the segregation of expatriate communities, language barriers and patients' ignorance of the problems as long as they have no real need.

Language barriers are reported by key-informants, when the patient and the provider do not speak the same language. In countries with different linguistic and cultural traditions to the home country, these factors can constitute a barrier to newcomers. Lack of a common language could lead to considerable problems in communication between patients and doctors. However, hospitals are becoming aware of the need to assist non-Spanish speakers and are beginning to include language skills as a criterion when hiring new staff.¹⁵

Conclusion

Analysis to date suggests that there is a great need for research on health needs and utilisation of health services; to explore UK pensioners' perceptions of the need for health care and their health care seeking behaviour; and to assess UK pensioners' perspectives of the responsiveness of health care services in Spain. Health care needs in this population are determined by their demographic situation (as the health profile of migrants differs somewhat from that of the general home and receiving country populations); their cultural background (language acting as a determinant of their health care seeking behaviour); and their administrative situation in a context of higher human mobility ('fixed laws, fluid lives').²⁰ In addition, it is also important to consider how local and regional authorities are planning health care services and what financial compensation mechanisms are agreed between Member States. An understanding of these issues would be beneficial for all the actors involved in planning health services and assuring their financial sustainability, and for those who wish to retire or have already retired in another Member State.

However, these effects are complex to study and some contradictions can be expected. Health status can act as a factor when taking the decision to move abroad,

as well as influencing how long a migrant stays in the host country. UK citizens are entitled to use the Spanish health system, but cultural barriers might prevent them from doing so. They might instead prefer to use private health care services or the UK NHS. The relative use of health services by unit is low (UK pensioners have relatively good health and prefer private and home care services), but the absolute use of health services by this growing and concentrated population could have an important effect on the dynamics of the health service. If government and policy makers promote immigration through the urbanisation process, they should also plan services that take into account the health status and health care needs of these newcomers.

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Choice, competition and the political left

Zachary Cooper and Julian Le Grand

Summary: Choice and competition can no longer be viewed as an exclusive tool of the political right. Beyond creating incentives to drive up quality and increase efficiency in the English NHS, choice and competition stand to promote equity. While many left-leaning critics are quick to point out ways in which choice and competition could induce inequity, few critics objectively compare the equity implications of choice and competition to the no-choice system which preceded it. This article lays out the basic arguments for how choice and competition stand to improve equity. If the political left is serious about reducing inequities in public services, the time is right for them to open their eyes to the potential for choice and competition.

Keywords: Equity, NHS, Choice, Competition, Collectivism, England

Since 1955, when Milton Friedman published *The Role of Government in Education*,¹ the political right has had a virtual monopoly on choice and competition in public services. Traditional thinking on the right posited that greater user choice of providers tied to a reimbursement system where money followed users' choices would promote both allocative and technical efficiency. The political left not only disputed the right's efficiency claims, but went one step further and argued that any increase in user choice would come at the expense of equity.

This left/right battle over choice and competition continued until quite recently, when left leaning policy-makers began to come around to the notion that choice and competition in public services might not be such a disaster. Not only did the political left begin to argue that choice and competition could incentivise efficiency, they began to draw attention to the fact that injecting choice and competition into public services could improve the care that is delivered to traditionally under served users.

We argue that this emphasis on the potential positive impact of choice and competition on equity is quite justifiable. In what follows, we draw on theory, past experience and empirical evidence to articulate a case for the equity benefits of choice and competition.

A new rhetoric...

From 2002 onwards, Tony Blair's Labour Party embarked on an ambitious reform agenda to modernise the English National Health Service (NHS). At the core of the former Prime Minister's health service reforms was a belief that greater user choice and provider competition would create a more personalised NHS with better quality and less inequity than traditionally collectivist public health systems.

Speaking in 2003, Tony Blair said:

"People should not forget the current system is a two-tier system when those who can afford it go private...choice mechanisms enhance equity by exerting pressure on low-quality or incompetent providers. Competitive pressures and

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